

Starfield Summit Issue Brief

DISCUSSION TOPIC

► **Community risk adjustment for primary care payment:** Should primary care payments be adjusted for community risk based on sociodemographic factors? What effect would this have on access, quality, and financial stability of health care for vulnerable populations and the institutions which serve them? How can this be designed and implemented most effectively?

Why This Is Important (*brief description*):

► Social determinants (SDOH) drive health status; clinical care is responsible for only 10-20% of health status but accounts for ~95% of US health care costs. Vulnerable populations with deleterious SDOH incur higher health care costs and suffer poorer health outcomes. This reality means that safety net providers are systematically undercompensated for true cost of care, and incentivizes the perverse practice of “cherry picking” populations served to maximize margins. Some now propose that providers be assessed on quality outcomes adjusted for SDOH and/or be paid at higher (risk-adjusted) rates for individuals or in communities with adverse SDOH. Examples of success in which healthcare professionals or systems assume responsibility for addressing SDOH are emerging, but questions of generalizability and sustainability remain. Also, concerns have been raised that risk-adjustment might validate low quality care for disadvantaged populations, remove incentives to improve care for these populations and/or mask and therefore perpetuate disparities in care.

What We Think We Know (*bulleted evidence + seminal references*):

► Social determinants of health (conditions in which we are born, grow, work, play, live and age) drive health status more than clinical care (and account for 1/3 of US deaths annually). Compared to other OECD countries, US spends 2X as much “downstream” on clinical care, but much less “upstream” on social services that impact health.

► Many interventions to address social determinants have now been shown to improve outcomes and/or decrease costs (e.g. housing: Housing First, Bud Clark Commons; childhood nutrition: Carolina Abecedarian Project; public safety: Baltimore Safe Streets; integrated health and social services: Hennepin Health; Michigan Public Health Institute Pathways to Better Health Community hub)

► Lessons learned: importance of cross-sector partnerships, shared data systems, aligned incentives, workforce training *but* questions about scalability and long-term cost-effectiveness remain

► ACA (and most public/private insurers) currently provide for risk adjustment only on the basis of age, sex and disease diagnoses, not for other sociodemographic factors (e.g. race, SES, education, etc).

► NQF in 2014 recommended risk adjustment for sociodemographic factors to assess quality outcomes but CMS disagreed, citing concerns re: 1) validating different standards of care and 2) masking disparities.

► CMS has highlighted importance of SDOH and launched “Accountable Care Communities” which includes funding of “bridge organizations” to spur coordinated delivery of clinical and social services

National Quality Forum. Risk adjustment for sociodemographic factors. 2014. 2. Lipstein S & Dunagan W. Ann Intern Med 161:594, 2014. 3. IOM. Accounting for social risk factors in Medicare payment. 2016. 4. BCBS of MA Foundation. Leveraging the social determinants of health. What works? 2015. 5. Alley D et al. NEJM 374:8, 2016. 6. AAHC Social Determinants of Health Initiative “wherehealthbegins.org” 7. IOM. Capturing social and behavioral domains and measures in electronic health records. 2015.



QUESTIONS FOR GROUP DISCUSSION (PRECONFERENCE)

Questions for Group Discussion (*add brief answers post-conference*)

1. If primary care payments are adjusted for community risk, will patients' experience improved access, quality and value? Will safety net providers experience improved financial stability? Or, will it, as some fear, facilitate substandard care and further perpetuate or enhance health disparities? What research or pilots are needed to generate the evidence needed to answer these questions?
2. Are current systems for recording sociodemographic factors (either on an individual or community level) adequate for determining risk-adjustment? Is the knowledge base adequate to do this fairly?
3. What changes in the following are needed to make community risk-adjusted payments successful in improving health status: Policy; Information Sharing; Health/Social Service Government Budgets; Evaluation Metrics; Workforce Training; Other?
4. Can the goals of risk adjustment be accomplished by changing provider payments (with current health care delivery systems) or do we need fundamental changes in health care/social service system design? If so, what changes will be required?

Ideas Worthy of Policymaker Attention (*lists ideas for policy preconference, refined ones post-conference*)

- ▶ "Health in all policies" approach (e.g. health impact of agricultural subsidies, tax breaks for community development in poor areas, transportation funding, support for "green space", education funding, early childhood interventions, criminal justice, etc.)
- ▶ Encourage multisector budgets for local, state, and federal governments- in other words, ensure that budget "buckets" are appropriately recognized e.g. "housing" budget should not benefit from costs being paid by "health" budget; savings to health systems by paying for SDOH from "social services" budgets should not accrue to health system. How can true multi-sector budgets be ensured?
- ▶ Fund demonstration projects on community risk-adjusted payments for primary and other health care, and that address "upstream" SDOH, and where payments might be used to fund specific services
- ▶ Fund research on risk-adjusted payments- methodology, effectiveness, metrics, etc.

Important Unanswered Questions & Ideas Worthy of Research Community Attention

1. What is the best methodology for designing community risk and individual risk-adjusted payments to providers (e.g. which parameters, extent of adjustment, duration of adjustment, etc.)?
2. Effectiveness of risk-adjusted payments- which health outcomes are improved by which risk adjustments given to whom? Are there differences in the role of public and private payors?
3. What are the beneficial and detrimental outcomes of risk-adjusted payments?